

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-019546

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 93

Primary Registration District No. _____

Registrar's No. 63-37

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood</u>		Length of stay in 1b <u>15 mos.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lockwood Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>Lockwood Memorial Hospital</u>		If outside, give location Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERT</u> Middle <u>ELMER</u> Last <u>FORTNER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1878</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Greene County, Mo.</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jacob Fortner</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Hanie</u>	
14. NAME OF HUSBAND OR WIFE <u>Effie Fortner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>	
16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT Address <u>Mrs. Effie Fortner, Greenfield, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>_____</u>		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>	
20f. CITY, TOWN, OR LOCATION <u>Greenfield Mo</u>		COUNTY <u>Dade</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>1/10/62</u> to <u>5/17/63</u> and last saw him alive on <u>5/17/63</u> Death occurred at <u>1:55 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Lee A. McNeel, Jr., M.D.</u>		22b. ADDRESS <u>Greenfield Mo</u>	
22c. DATE SIGNED <u>5/17/63</u>		22d. LOCATION (City, town, or county) <u>Dade County, Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 19, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pennsboro Cemetery</u>		23d. LOCATION (City, town, or county) <u>Dade County, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Marsh Funeral Home, Inc., Aurora, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 18, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>		27. _____	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
ORTYPEWRITER, RIBBON
Lee A. McNeel, Jr., M.D.VS 300
Rev. 4/591 02902 0290

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12 1-013 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Everett Crawford, Jr., Student Embalmer No. 675

working under my personal supervision.

Student

Everett Crawford, Jr.
Signature of Student Embalmer

Signed

[Signature]

Licensed Embalmer No.

4213

P. O. Address

Monett, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.